K43056

ALVARADO HOSPITAL
San Diego, California 92120

Visit #: 20205936
MR #: 707153
Patient: VELARDE, HAROLD
Location: 4NE 415/A
Admitting Physician: Jonathan J. Myer, MD
Admit Date: 10/07/2009
Service Date: 10/09/2009
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OPERATIVE REPORT

cc: Rodney G. Hood, MD (FAX)
Lisa Tibor, MD (FAX)
Jonathan J. Myer, MD (FAX)

PREOPERATIVE DIAGNOSIS(ES)
1. History of previous right distal femur fracture from gunshot wound in 2005, with subsequent open reduction, internal fixation, and subsequent iliac crest bone grafting, with subsequent removal of hardware 6 months ago.
2. Right distal femur and deep orthopedic hardware.
3. Right knee severe traumatic osteoarthritis.
4. Right distal femur bony deformity.

POSTOPERATIVE DIAGNOSIS(ES)
1. History of previous right distal femur fracture from gunshot wound in 2005, with subsequent open reduction, internal fixation, and subsequent iliac crest bone grafting, with subsequent removal of hardware 6 months ago.
2. Right distal femur and deep orthopedic hardware.
3. Right knee severe traumatic osteoarthritis.
4. Right distal femur bony deformity.

OPERATIVE PROCEDURE
1. Open reduction and internal fixation of right distal femur fracture, with increased level of difficulty secondary to 3 previous surgeries in this same area.
2. Right knee removal of the orthopedic hardware.

SURGEON: Jonathan J. Myer, MD

ASSISTANT: Lisa Tibor, MD

ANESTHESIA: Preoperative femoral nerve block plus general endotracheal anesthesia.

ESTIMATED BLOOD LOSS: 300 mL.

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TOURNIQUET TIME: 1 hour 54 minutes.

CRYSTALLOID: 900.

CONDITION: Stable.

COMPLICATIONS: None.

PATIENT INDICATIONS: The patient is a 31-year-old male who had a right distal femur fracture with history of 3 previous surgeries in the same area with knee arthritis, who was indicated for open reduction and internal fixation of the distal femur fracture with possible removal of hardware, possible allograft. Complete indications are dictated in the preoperative history and physical. Informed consent was obtained for the procedure.

PROCEDURE IN DETAIL: The patient was identified in the holding area. The right knee was marked by the patient as well as surgeon, confirming the correct operative site. The patient was then transported to the operating room, placed in the supine position on the operating room table. General endotracheal was obtained after smooth induction and preoperative antibiotics. A preoperative femoral nerve block was then performed. At this point, tourniquet was placed on the upper thigh of the patient. The right lower extremity was then prepped and draped in the usual sterile fashion for orthopedic extremity surgery with Betadine-based prep and impervious stockinette.

At this point, we Esmarched the limb and inflated the tourniquet, and at this point, we used the patient's previous lateral incision in its entirety. The patient had had previous surgeries. We went through skin. There was a tremendous amount of scar material under this. We dissected through this combination with blunt versus sharp dissection until the scarred-in iliotibial band was approached. This was incised and proximally to reveal the vastus lateralis distally. This was taken down to bone over the distal femur fragment, as it was all 1 layer with scar material. As there was no time to perform the

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dissection, through the scar we were able to discern that we could elevate the vastus lateralis, dissecting it, freeing it up the posterior fascia, and elevating it anteriorly. A combination of blunt and sharp dissection was carried out through the scar material and brought down to bone and exposed the fracture. We irrigated it out with a copious amount of irrigation solution. There was intervening clot and soft tissues.

The combination of blunt versus sharp dissection was used to reveal the fracture. There were 2 main fragments that were seen, there was comminution, particularly on the lateral side of the butterfly fragment. This was left attached to soft tissues. We reduced the fracture after placing a Bennett anteriorly, exposed the fracture edges. We tried to hold it temporarily with some K-wires brought from both medial and lateral, staying off the articular cartilage, and bringing them proximally. That held it in place a little bit, but completely. At this point, we placed the Synthes 8-hole distal femur plate in standard fashion, and fixated it distally with locking screws. There was a lot of sclerotic bone which we had to go through. We had excellent purchase and excellent fixation distally. Then we fixated the plate with compression, using the compression hole proximally. This gained us significant compression, but also did lateralize the proximal fragment slightly. We felt this was like a 1-mm translation. I felt this was acceptable, especially since we had good compression.

We then filled in some other more proximal locking screws, and made a stab incision for a more proximal screw through the skin, not feeling that we needed to extend the incision in order to get a proper fixation. We were satisfied with our fixation. We took final fluoroscopic views, irrigated it out with a copious amount of irrigation solution. We had decided that we had to reduce the fracture as anatomic as possible to restore the patient's bone stock. We knew that the distal femur, including intra-articular, had significant deformity, which it would not be wise to fix at this setting. We accepted reducing it as anatomically as possible for this patient's anatomy. We were satisfied with our result. It

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should be mentioned that after exposure, there were 2 large fragment cortical screws, which would possibly have been in our way for our plate and screws, and therefore they were removed in their entirety, consisting of removal of the deep orthopedic hardware. This was done without complication.

We irrigated out with a copious amount of irrigation solution. The patient's knee had significant deformity and arthritis, and lacked about 20 degrees of full extension. We irrigated it out once again, let the tourniquet down, obtained hemostasis with the electrocautery, and then closed the deep scarred-in iliotibial band distally with an interrupted figure-of-eight #2 Ethibond stitch in full thickness distally, and proximally closed the iliotibial band in the same fashion. We got a good repair. We then closed the subcutaneous scarred tissue with a 2-0 Vicryl, used staples for skin, applied antibiotic ointment, Xeroform, sterile gauze, and a bulky Jones. The drain had been placed deep to the iliotibial band. This was brought out distally. A knee immobilizer was placed. The patient was awakened from anesthesia and transported to the recovery room in stable condition, having tolerated the procedure well. All needle, sponge, and instrument counts were correct at the end of the case. No complications in this case.

JM:aaj
D: 10/09/2009 8:43 PM
T: 10/09/2009 10:59 PM
JOB: 147772

_____
Jonathan J. Myer, MD

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Consultation Date:	10/08/2009

CONSULTATION

Again, we talked about the surgery, open reduction, internal fixation, right distal femur fracture, with possible removal of hardware, possible allografting. We talked about the rehabilitation process. The risks, benefits, alternatives, of this procedure were discussed in full with the patient. Informed consent was obtained, including the possible needed for transfusion. He demonstrates risks, benefits, alternatives to this. Informed consent was obtained. He wished to proceed with the procedure. We will make a decision on when to schedule him. For now, we should used mechanical DVT prophylaxis with foot pump and receive a dose of Fragmin today, possibly tomorrow, depending on whether surgery is planned. We will decide this later today.

The patient was seen and evaluated at 1 p.m. on 10/08/2009.

JM:arw
D: 10/08/2009 11:12 PM
T: 10/08/2009 11:47 PM
JOB: 147572

Jonathan J. Myer, MD

ADDENDUM: TO BE USED BY THE SURGEON TO UPDATE - AS HISTORY AND PHYSICAL PRIOR TO SURGERY (24 HOURS)

If you are a surgeon and you will utilize the Consultation as an updated H&P, please note after examination of the patient:

Findings are the same: _____ (check if same) and/or the following changes are:

_____

_____

DATE: 10/9/09 TIME: 5pm SIGNATURE OF SURGEON: _____

ORIGINAL

VERIFICATION

7A

STATE OF CALIFORNIA
COUNTY OF IMPERIAL

(C.C.P. SEC.446 & 201.5; 28 U.S.C. SEC. 1746)

I, Harold A. Velarde DECLARE UNDER PENALTY OF PERJURY THAT: I AM THE Plaintiff IN THE ABOVE ENTITLED ACTION; I HAVE READ THE FOREGOING DOCUMENTS AND KNOW THE CONTENTS THEREOF AND THE SAME IS TRUE OF MY OWN KNOWLEDGE, EXCEPT AS TO MATTERS STATED THEREIN UPON INFORMATION, AND BELIEF, AND AS TO THOSE MATTERS, I BELIEVE THEM TO BE TRUE.

EXECUTED THIS 8th DAY OF: February 20 11 AT CALIPATRIA STATE PRISON, CALIPATRIA, CALIFORNIA #92233-5002

(SIGNATURE) Harold Velarde
(DECLARANTIPRISONER)

PROOF OF SERVICE BY MAIL

(C.C.P. SEC.1013 (a) & 2015.5; 28 U.S.C. SEC.1746)

I, Harold A. Velarde AM A RESIDENT OF CALIPATRIA STATE PRISON, IN THE COUNTY OF IMPERIAL, STATE OF CALIFORNIA. I AM OVER THE AGE OF EIGHTEEN (18) YEARS OF AGE AND AM / NOT A PARTY OF THE ABOVE-ENTITLED ACTION. MY STATE PRISON ADDRESS IS: P.O. BOX 5002. CALIPATRIA, CALIFORNIA #92233-5002.

ON 2/8 20 11 I SERVED THE FOREGOING: _____

(SET FORTH EXACT TITLE OF DOCUMENTS SERVED)

ON THE PARTY (S) HEREIN BY PLACING A TRUE COPY (S) THEREOF, ENCLOSED IN A SEALED ENVELOPE (S), WITH POSTAGE THEREON FULLY PAID, IN THE UNITED STATES MAIL, IN A DEPOSIT BOX SO PROVIDED AT CALIPATRIA STATE PRISON, CALIPATRIA, CALIFORNIA #92233-5002.

(3) Copies of 42 U.S.C 193, (1) In Forma Pauperis, (1) Inmate 6 month account statement, (1) Application For Waiver of court fees and costs, (1) Request for appointment of counsel, (1) copy of operative report

THERE IS DELIVERY SERVICE BY UNITED STATES MAIL AT THE PLACE SO ADDRESSED, AND THERE IS REGULAR COMMUNICATION BY MAIL BETWEEN THE PLACE OF MAILING AND THE PLACE SO ADDRESSED. I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

DATE: 2/8/11

Harold Velarde
(DECLARANTIPRISONER)